MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION
DISABILITY QUESTIONNAIRE

NAME _____ DCN _____ DATE _____

Pertinent Information and Observations of the Eligibility Specialist: _____

1. Personal Information: Age __ Sex _ Height ____ Weight ___

2. Highest Grade Completed: __ GED ☐ Yes ☐ No

3a. What physical symptoms/problems do you have? _____

3b. What mental health symptoms/problems do you have? _____

Do you have crying spells or depression because of your disability? ☐ Yes ☐ No How Often? _____

3c. Are your mental health symptoms due to your current circumstances (i.e. family, job, health)? ☐ Yes ☐ No

4. When did these symptoms/problems begin? _____

5. When did these symptoms first prevent you from working? _____

6. What are the limitations of your daily activities from this disability? Please list those you are **unable** to perform :

Able to perform? _____

Are you in need of caretaking? ☐ Yes ☐ No
If yes, who provides? (Check one) ☐ Nurse ☐ Relative ☐ Neighbor ☐ Friend ☐ Other

7. Did you see a doctor or seek medical treatment for your symptoms? ☐ Yes ☐ No
Physician _____ How often? _____
Treatment received: _____
When? _____
Physician _____ How often? _____
Treatment received: _____
When? _____

8. Have you been given a specific diagnosis for your problem? ☐ Yes ☐ No What is the diagnosis? _____

9. Have you gone to Vocational Rehabilitation? ☐ Yes ☐ No (If yes, obtain VR reports and any medical examinations required by VR) What is the status of your Vocational Rehabilitation referral? _____

10. Have you applied for (Check if applicable) ☐ Social Security ☐ SSI ☐ VA ?
Were you examined by a doctor for this application? ☐ Yes ☐ No (If yes, obtain medical reports from SSA)
What is the status of your application? _____

11. Did your problem require physical therapy? ☐ Yes ☐ No (Obtain medical information or reports)
If yes, where? When? _____
Describe therapy _____

12. Describe any pain you have from these problems. (If specialized care was received for this pain, obtain medical reports) _____

13. List medications you take, prescribed or over-the-counter, side effects and how often medication is taken :

14. Who prescribed the medications? (Obtain medical information) _____

15. Have you been treated by or referred to a(n):

	YES	NO	REFERRED	TREATED
Orthopedist	☐	☐	☐	☐
Internist	☐	☐	☐	☐
Neurologist	☐	☐	☐	☐
Cardiologist	☐	☐	☐	☐
Psychologist/Psychiatrist	☐	☐	☐	☐
Other Specialist	☐	☐	☐	☐

16. Have you been hospitalized due to your disability or illness? ☐ Yes ☐ No
If yes, where? _____
How long? Dates? _____
Admitting physician name _____

Medical information **must be current** (within the past 12 months). It must include information on each of the claimant's complaints. If not current or complete, schedule an examination.

ADDITIONAL INFORMATION AND COMMENTS

ITEM NO.	